BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **GARY L. LOWERY, M.D.** Holder of License No. 24907 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-03-1116A **CONSENT AGREEMENT FOR DECREE OF CENSURE**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Gary Lowery, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government

regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

5. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

6. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

7. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

Gary L. Lowery MD PhD DATED: 3/14/2006

GARY L. LOWERY, M.D.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 24907 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-03-1116A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a 57 year-old male patient ("R.B.").

4. On March 8, 2000 R.B. sustained a L4 level burst fracture while at work. On April 17, 2000 R.B. underwent a decompressive laminectomy at the L4 level, but continued to experience back pain. R.B. was treated conservatively for his back pain, but was eventually referred to Respondent for surgery.

5. On December 4, 2000 R.B. presented to Respondent for an anterior carpectomy at the L4 level followed by a posterolateral fusion.

6. Respondent did not have unsupervised privileges to perform spinal surgery at the hospital, but Respondent elected to perform the surgery without a supervisor present. Respondent stated to Board Staff that he was unaware that he needed a supervisor for every case he performed.

7. The operative record reflected Respondent's approach to the spine took between four and five hours. R.B. was a stocky, obese patient. However, even given the difficulties of this patient, the approach should have taken no more than two hours.

8. During the procedure Respondent estimated R.B.'s blood loss to be between 1,000 and 3,000 cc. However, there were discrepancies among those involved in the procedure of the actual amount of blood lost. Respondent's hand written note immediately following the procedure estimated the blood loss to be 6,000 cc with 3,000 cc returned.

The cell saver technician and the anesthesiologist listed the estimated blood loss to be 6,000 cc. The nursing notes listed the replacements of fluid to be 10,000 cc of fluid and seven units of blood. These discrepancies suggested Respondent was confused regarding the amounts of blood lost during the procedure.

9. Respondent dictated that a Vascular Surgeon ("Vascular Surgeon") did the approach to the vessels anterior to R.B.'s spine. However, according to the scrub technician Respondent made the skin incision and approach to the retroperitoneal area. There were no operative reports from Vascular Surgeon to suggest that he did the approach.

10. The anesthesia record stated that R.B. began to experience bradycardia and hypotension beginning around 1500, about 6.5 hours into the surgery. Respondent did not order a blood gas until 1540. The blood gas showed a pH of 6.966 indicating R.B. was suffering immediate and severe cardiovascular instability.

11. Respondent continued the procedure even though R.B. suffered two more cardiac arrests.

12. Respondent closed R.B. following the third cardiac arrest. However, after noticing that R.B. had a retained sponge, Respondent elected to reopen R.B. to retrieve the sponge.

13. R.B. suffered a fourth and final cardiac arrest and was not able to be resuscitated. R.B. was pronounced dead at 1820 hours, approximately 10 hours after the surgery began.

14. The standard of care for the intra-operative management of a cardiac event during an elective surgery required Respondent to stabilize the patient if there is evidence of a serious problem. The standard of care also required Respondent to appropriately manage the patient's blood loss.

15. Respondent deviated from the standard of care because he failed to manage the patient's blood loss during the surgery and because he continued an elective surgery in the face of cardiac instability.

16. R.B. died as a result of the prolonged surgery.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(e) – ("[f]ailing or refusing to maintain adequate records on a patient.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(q) – ("[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.").

4. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(ll) – ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure for inaccurate medical records, performing a surgical procedure without proper privileges and qualifications, and incompetently performing surgery resulting in the death of a patient.

2. This Order is the final disposition of case number MD-03-1116A.

DATED AND EFFECTIVE this 6th day of April, 2006.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
TIMOTHY C.MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 7th day of April, 2006 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 7th day of April, 2006 to:

Mr. Steve Myers
Myers & Jenkins PC
3003 N Central Avenue, Suite 1900
Phoenix, AZ 85012-2910

EXECUTED COPY of the foregoing mailed this 7th day of April, 2006 to:

Gary L. Lowery, M.D.
Address of Record

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Investigational Review